

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

12048 63-045364

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED DEC 12 1963

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair c. CITY OR TOWN East St. Louis, Illinois Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 427 North 14th Street Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROSIE Middle DEAN Last 5. SEX Female 6. COLOR OR RACE Negro 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> 8. DATE OF BIRTH 3/26/01 9. AGE (last birthday) 59 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (City and state or country) Columbus, Mississippi 12. CITIZEN OF WHAT COUNTRY U.S.A. 13a. FATHER'S NAME JOHN LANG 13b. MOTHER'S MAIDEN NAME SAVANNAH (UNKNOWN) 14. NAME OF HUSBAND OR WIFE NONE			4. DATE OF DEATH Month December Day 3 Year 1963 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. [REDACTED] 17. INFORMANT East St. Louis, Illinois Jeffrie Bolden, 427 North 14th Street,		
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 4221 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown				INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour - - - - - a.m. - - - - - p.m. - - - - -		Month, Day, Year			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 11/26/63 to 12/3/63 and last saw her alive on 12/3/63 Death occurred at 8:00 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) FR. Bradley M.D. FRANK R. BRADLEY, M.D.		22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 12/4/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/8/63		23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memory	
23d. LOCATION (City, town, or county) Stookey Township, St. Clair,		23e. DATE RECD. BY LOCAL REG. DEC 6 1963		23f. REGISTRAR'S SIGNATURE Road Smith, H.D.	
24. FUNERAL DIRECTOR Marionette Office		24a. ADDRESS 2114 Missouri Avenue East St. Louis, Illinois		24b. LICENSED EMBALMER'S STATEMENT ON REVERSE SIDE	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300
Rev. 4/59
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2 8/28
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52

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed _____

Marion C. Officer

Licensed Embalmer No. 4177

P. O. Address C. St. Louis, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.